PRINTED: 09/10/2009 FORM APPROVED Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING NVS2478AGC 08/25/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 220 CARLIN AVE **SUN VALLEY CARE HOME** LAS VEGAS, NV 89110 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Y 000 Y 000 **Initial Comments** The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of an annual State Licensure survey conducted at your facility on 8/25/09. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility was licensed for six (6) Residential Facility for Group beds for elderly and disabled person and/or persons with mental illness. The census at the time of the survey was 5 residents. Five (5) resident files were reviewed and three (3) employee files were reviewed. One (1) discharged resident file was reviewed. The facility received a grade of A. There were no complaints investigated. The following deficiencies were identified: Y 105 Y 105 449.200(1)(f) Personnel File - Background Check SS=E

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

This Regulation is not met as evidenced by: Based on record review on 8/25/09, the facility

1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (f) Evidence of compliance with NRS 449.176 to

NAC 449 200

449.185, inclusive.

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Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
NVS2478AGC				B. WING		08/25/2009	
NAME OF PROVIDER OR SUPPLIER SUN VALLEY CARE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 220 CARLIN AVE LAS VEGAS, NV 89110				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FU REGULATORY OR LSC IDENTIFYING INFORMATI			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
Y 105	Continued From page 1 failed to ensure 1 of 3 caregivers met background check requirements (Employee #2 -most recent fingerprints & criminal history response was dated 3/4/04). Severity: 2 Scope: 2			Y 105			
Y 859 SS=E	449.274(5) Periodic Physical examination of a resident NAC 449.274 5. Before admission and each year after admission, or more frequently if there is a significant change in the physical condition of a resident, the facility shall obtain the results of a general physical examination of the resident by his physician. The resident must be cared for pursuant to any instructions provided by the resident's physician.			Y 859			
	Based on record revi	ot met as evidenced by ew on 8/25/09, the facil 2 of 5 residents receive cal (Resident #3 and #5	ity d a				
Y 870 SS=E	449.2742(1)(a)(1)(2)(Medication Administr	(b)(c) 449.2742(1)(a)(1) ation		Y 870			
	NAC 449.2742 1. The administrator provides assistance to	of a residential facility the residents in the	nat				

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FORM APPROVED Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING NVS2478AGC 08/25/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 220 CARLIN AVE **SUN VALLEY CARE HOME** LAS VEGAS, NV 89110 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Y 870 Continued From page 2 Y 870 administration of medications shall: (a) Ensure that a physician, pharmacist or registered nurse who does not have a financial interest in the facility: (1) Reviews for accuracy and appropriateness, at least once every 6 months the regimen of drugs taken by each resident of the facility, including, without limitation, any over-the-counter medications and dietary supplements taken by a resident. (2) Provides a written report of that review to the administrator of the facility; (b) Include a copy of each report submitted to the administrator pursuant to paragraph (a) in the file maintained pursuant to NAC 449.2749 for the resident who is the subject of the report. (c) Make and maintain a report of any actions of any actions that are taken by the caregivers employed by the facility in response to a report submitted pursuant to paragraph (a). This Regulation is not met as evidenced by: Based on record review on 8/25/09, the facility did not ensure that a medication profile review was performed by a physician, pharmacist or registered nurse at least once every six months for 2 of 5 residents residing in the facility for longer than six months (Resident #3 and #5). Severity: 2 Scope: 2

449.2746(2)(a)-(f) PRN Medication Record

Y 908

SS=A

Y 908

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If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Y 936 449.2749(1)(e) Resident file-NRS 441A

1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after he permanently leaves the facility. The file must be kept locked in a place

Tuberculosis

NAC 449.2749

SS=F

Y 936

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